DOCUMENT RESUME

ED 333 657 EC 300 413

AUTHOR	Zabel, Mary Kay
TITLE	Teaching Young Children with Behavioral Disorders. Working with Behavioral Disorders: CEC Mini-Library.
INSTITUTION	Council for Exceptional Children, Reston, Va.; ERIC Clearinghouse on Handicapped and Gifted Children, Reston, Va.
SPONS AGENCY	Office of Educational Research and Improvement (ED), Washington, DC.
REPORT NO	ISBN-0-86586-200-1
PUB DATE	91
NOTE	32p.; For other documents in this set, see EC 300 409-417.
AVAILABLE FROM	Council for Exceptional Children, Publication Sales, 1920 Association Dr., Reston, VA 22091 ($8.90 each, $72.00 set of nine; members, $6.25 each, $50.00 set; stock no. P341).
PUB TYPE	Information Analyses - ERIC Clearinghouse Products (071)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Behavior Disorders; Behavior Modification; Compliance (Legal); Curriculum Development; Delivery Systems; Developmental Programs; *Early Childhood Education; *Early Intervention; Educational Legislation; *Educational Methods; Federal Legislation; Interpersonal Competence; Models; Preschool Education; Program Development; Psychoeducational Methods; Publicity; Young Children
IDENTIFIERS	*Education of the Handicapped Act Amendments 1986

ABSTRACT

This booklet reviews the literature and considers applications of Public Law 99-457 (Education of the Handicapped Act Amendments--1986) in developing programs for young children with behavior disorders. The following topics are considered: provisions of the law (states are required to provide a free, appropriate public education to all eligible children, ages 3 to 5, by 1991); intervention services (the law encourages efforts focused on collaboration, prevention, and family-centered services); public awareness campaigns (parents need to be alerted to program availability); developmental therapy (a curriculum model based on the child's current level of performance and behavior rather than chronological age); the engineered or orchestrated classroom (a model focused on creating a "harmonious learning climate"); the psychoeducational model (the security and comfort of a predictable structure and schedule are central); behavior modification (interventions are based on positive reinforcement, timeout, and natural consequences); social skills development (direct instruction is usually most effective with this population); focus on family (family strengths and needs are addressed rather than child deficits); teacher training and professional resources (both general and special educators need more information about behavioral disabilities, strategies that work, and ways of collaborating). Includes 42 references. (DB)

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Working with Behavioral Disorders

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TEACHING YOUNG CHILDREN WITH BEHAVIORAL DISORDERS

Mary Kay Zabel

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Working with Behavioral Disorders

Teaching Young Children with Behavioral Disorders

Mary Kay Zabel

A Product of the ERIC Clearinghouse on Handicapped and Gifted Children
Published by The Council for Exceptional Children

Library of Congress Cataloging-in-Publication Data

Zabel, Mary Kay.
Teaching young children with behavioral disorders / Mary Kay Zabel.
p. cm. — (Working with behavioral problems)
"A product of the ERIC Clearinghouse on Handicapped and Gifted Children."
CEC mini-library
ISBN 0-86586-200-1 (pbk.)
1. Problem children—Education—United States. I. ERIC Clearinghouse on Handicapped and Gifted Children. II. Title. III. Series.
LC4802.Z33 1991
371.93—dc20 91-8465
CIP

ISBN 0-86586-200-1

A product of the ERIC Clearinghouse on Handicapped and Gifted Children

Published in 1991 by The Council for Exceptional Children, 1920 Association Drive, Reston, Virginia 22091-1589.
Stock No. P341

This publication was prepared with funding from the U.S. Department of Education, Office of Educational Research and Improvement, contract no. RI88062007. Contractors undertaking such projects under government sponsorship are encouraged to express freely their judgment in professional and technical matters. Prior to publication the manuscript was submitted for critical review and determination of professional competence. This publication has met such standards. Points of view, however, do not necessarily represent the official view or opinions of either The Council for Exceptional Children or the Department of Education.

Printed in the United States of America
10 9 8 7 6 5 4 3 2 1

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Foreword

Working with Behavioral Disorders
CEC Mini-Library

One of the greatest underserved populations in the schools today is students who have severe emotional and behavioral problems. These students present classroom teachers and other school personnel with the challenges of involving them effectively in the learning process and facilitating their social and emotional development.

The editors have coordinated a series of publications that address a number of critical issues facing service providers in planning and implementing more appropriate programs for children and youth with severe emotional and behavioral problems. There are nine booklets in this Mini-Library series, each one designed for a specific purpose.

- *Teaching Students with Behavioral Disorders: Basic Questions and Answers* addresses questions that classroom teachers commonly ask about instructional issues, classroom management, teacher collaboration, and assessment and identification of students with emotional and behavioral disorders.
- *Conduct Disorders and Social Maladjustments: Policies, Politics, and Programming* examines the issues associated with providing services to students who exhibit externalizing or acting-out behaviors in the schools.
- *Behaviorally Disordered? Assessment for Identification and Instruction* discusses systematic screening procedures and the need for functional assessment procedures that will facilitate provision of services to students with emotional and behavioral disorders.

- *Preparing to Integrate Students with Behavioral Disorders* provides guidelines to assist in the integration of students into mainstream settings and the delivery of appropriate instructional services to these students.
- *Teaching Young Children with Behavioral Disorders* highlights the applications of Public Law 99–457 for young children with special needs and delineates a variety of interventions that focus on both young children and their families.
- *Reducing Undesirable Behaviors* provides procedures to reduce undesirable behavior in the schools and lists specific recommendations for using these procedures.
- *Social Skills for Students with Autism* presents information on using a variety of effective strategies for teaching social skills to children and youth with autism.
- *Special Education in Juvenile Corrections* highlights the fact that a large percentage of youth incarcerated in juvenile correctional facilities has special learning, social, and emotional needs. Numerous practical suggestions are delineated for providing meaningful special education services in these settings.
- *Moving On: Transitions for Youth with Behavioral Disorders* presents practical approaches to working with students in vocational settings and provides examples of successful programs and activities.

We believe that this Mini-Library series will be of great benefit to those endeavoring to develop new programs or enhance existing programs for students with emotional and behavioral disorders.

Lyndal M. Bullock
Robert B. Rutherford, Jr.

Introduction

Public Law 99-457 represents a new phase in the evolution of special education in the United States. Just as P.L. 94-142 ushered in an era of substantial change in the provision of services to school-age children with disabilities, the current legislation will provide many services to children under school age, who had not been receiving assistance. When P.L. 94-142 was implemented in 1978, many states already were serving children with various disabilities. Even so, the federal mandate requiring a free, appropriate education to all children caused a tremendous upheaval in service provision in many areas and categories, reflected by increased numbers of classes and service models in the public schools. With the passage of P.L. 99-457, states are now being encouraged to provide such services to children age 3 and over, as well as to plan carefully for service to infants and their families. For those concerned with the education and treatment of children with behavioral disorders, this most recent piece of legislation provides a long-sought opportunity to begin introducing intervention to children at younger ages. Early intervention is suggested as a strategy in almost every area of educational endeavor (Kirk, 1977; Skeels & Dye, 1939) and is currently being suggested as a helpful strategy for at-risk, delinquent, and substance abuse prevention programs.

Young children with behavior disorders (BD), or those who exhibit disturbing behavior, present a special challenge to the teacher or other professional. While the number of children labeled as BD or seriously emotionally disturbed (SED) under age 5 is fairly small, teachers consistently report the presence of such children in their programs. As programs with various titles begin to serve larger numbers of children, teachers and other professionals will need to provide more services to children in this area. This resource is designed to assist teachers of young children to identify concepts and models in both the BD and early

childhood special education (ECH) literature that may be helpful in designing intervention strategies.

These areas have much in common. Both BD and ECH cross definitional boundaries, in that ECH programs often serve children with disabilities by age rather than by categorical definition, and BD programs often include children with a variety of other disabilities (e.g., mental retardation, learning disability, hearing impairment). This crossing of boundaries puts professionals in a unique position to offer services in a variety of settings and delivery models, as well as to provide extensive consultation and support to other programs.

Another point of common focus between the fields of BD and ECH is the area of assessment. All areas of special education wrestle with the dilemma of appropriate assessment and diagnostic procedures; but both BD and ECH rely heavily on observation as a primary tool, recognizing that situation and context are crucial to the definition of specific abilities and disabilities in these areas. In addition, BD and ECH are the result of the merging of several fields. The area of behavior disorders has roots in general education, psychology, psychiatry, and social work, whereas early childhood special education embraces education, early childhood education, medicine, speech pathology, and child development.

1. Provisions of the Law

P.L. 99-457 requires states to provide a free, appropriate, public education to all eligible children, ages 3 to 5, by 1991.

P.L. 94-142 required that states serve all children with disabilities between 6 and 17 years of age by providing special education and related services necessary for the child's growth and educational development. Under P.L. 94-142 (Part B of the Education for All Handicapped Children Act), states could serve preschool children (ages 3-5) if there was no state law against such service. If an individual state chose to serve children in this age group, federal monies were available. Preschool incentive grants were made available to encourage states to serve this population. As with much of the funding for P.L. 94-142, however, the proposed dollar ceilings were never reached. In the preschool area, for instance, the ceiling was to have been $300 per child; in fact, the amount of reimbursement averaged $110.

Public Law 99-457 seeks to rectify this underfunding by providing a gradual increase in support to a ceiling of $1,000 (Garwood & Sheehan, 1989). Other funds also are to be allocated for increases in the number of children being served. In addition, a limited mandate stipulates that by

1990 (changed to 1991 because of funding restrictions), all states must provide a free and appropriate public education to all eligible preschool (age 3-5) children with disabilities. If any state fails to do so, that state is prohibited from receiving grant funds that may be provided under Parts C through G of the Education for All Handicapped Children Act.

2. Intervention Services

P.L. 99-457 encourages that efforts be focused on collaboration, prevention, and family-centered services.

Another significant part of this legislation is referred to as "Part H." This section funds state planning and development initiatives to create a "statewide, comprehensive coordinated, multidisciplinary, interagency program of early intervention services for handicapped infants, toddlers and their families" (Garwood & Sheehan, 1989). The minimum components for such a statewide system are outlined in Figure 1. As can be seen, special educators and other professionals involved in serving young children and their families are encouraged to focus their efforts on collaboration, prevention, and family-centered service provision.

In addition, Part H activities focus on conditions that may put an infant at developmental risk. A glance through a list of such conditions reveals significant overlap with issues that have occupied professionals in the field of behavioral disorders for many years (see Figure 2).

The connections among poverty, single parenthood, teenage parenthood, fetal alcohol syndrome (FAS), failure to thrive (FTT), abuse, nutrition, and future mental health are unmistakable. The fact that these issues also are being addressed as part of Part H planning and intervention provides significant overlap with the field of behavioral disorders. Many programs originally designed for teenagers with behavioral disorders, for instance, may have something to offer those attempting to work with young parents. The social skills and vocational awareness/training sections of such programs would be particularly useful (Goldstein, Sprafkin, Gershaw, & Klein, 1980).

Part H also puts great emphasis on interagency planning, setting the stage for those concerned primarily with behavior disorders and mental health to work closely with planners in the areas of infancy, service delivery, and prevention. The variety of services that could emerge and be seen as potentially useful to the interagency planning process is substantial, and the organization of such an array of services will require careful case management and organization (see Figure 3).

Mental health service providers and special educators with a knowledge of behavior disorders will clearly need to be a part of many

FIGURE 1
Minimum Requirements for Implementing a Comprehensive Early Intervention System

1. Definitions of developmental delay
2. A timetable for availability of services
3. A comprehensive, multidisciplinary evaluation of the needs of children and families
4. An individualized family service plan (IFSP) that includes case management services
5. A child-find and referral system
6. A public awareness program to focus on early identification
7. A central directory of services, resources, state experts, and research and demonstration projects
8. A comprehensive system of personnel development
9. A single line of authority to a lead agency
10. A policy for contracting or making arrangements with local service providers
11. A procedure for timely reimbursement of funds
12. Procedural safeguards
13. Policies and procedures for personnel standards
14. A system for compiling data regarding the early intervention program

Source: Healy, A., Keesee, P., & Smith, B. (1989). *Early services for children with special needs: Transactions for family support.* Baltimore: Paul Brookes.

teams. An understanding of psychological processes and interactions and a sensitive ability to interact with people in stressful situations are clearly a part of the training and professional practice of such individuals, and their presence will be a useful component of the interagency interaction process.

FIGURE 2
Conditions That May Put an Infant's Development at Risk: U.S. Statistics

Poverty: About 25% of all babies are born into poverty; in 1983, 3,527,000 children under age 4 were living in poverty in the United States.

Single Parent: In 1983, 20% of all newborn babies were born to single mothers, a 5-fold increase since 1950.

Teenage Parent: The birth rate for unmarried white adolescents is about 66% of its 1970 rate; the rate for Blacks is 400% of that for Whites.

Low Birth Weight: About 250,000 babies are born annually weighing less than 2,500 grams; of these, more than 43,000 weigh less than 1,500 grams.

Congenital Anomalies: Between 100,000 and 150,000 infants are born each year with congenital anomalies that will lead to mental retardation.

Fetal Alcohol Syndrome (FAS): More than 3,700 infants are born annually with FAS.

Failure to Thrive (FTT): FTT (consistently below the third percentile on growth) affects 3% of the pediatric population, and is especially prevalent among infants less than 18 months of age.

Mental Health: While there are no national data, a representative New York county study revealed that children under 4 represented 16% of patients diagnosed with mental health problems. Maternal depression, marital disharmony, and poor parent-child relationships positively correlated with child mental health problems.

Abuse: Infants and toddlers who are abused represent about 6% of the general population.

Nutrition: A 1982 Center for Disease Control survey of children under age 2 revealed that 8.3% were under the 5th percentile for height.

Environmental Poisons: About 18% of Black children and 3% of White children under age 3 have elevated blood lead levels.

Source: Garwood, S. G. & Sheehan, R. (1989). *Designing a comprehensive early intervention system: The challenge of Public Law 99-457*. Austin, TX: Pro-Ed.

FIGURE 3
Interagency Planning Options

Adaptive Equipment	Nursing
Audiology	Nutrition Counseling
Case Management	Occupational Therapy
Consultation	Parent Education
Counseling Parents	Pediatric Medicine
Day Care	Physical Therapy
Diagnosis	Preventive Services
Evaluation	Psychological/Psychiatric Services
Financial Assistance	Referral
Follow-up	Regular Education
Foster Care	Residential Services
Homemakers Service	Respite Care
Home Nursing	Screening
Hospice Care	Sign Language
IEP Development	Special Education
Instructional Materials	Speech/Language Services
Language Translation	Staff Training
Legal Advocacy	Transportation
Leisure Time Planning	Vision Services
Mainstreaming	
Mobility Training	

3. Public Awareness Campaigns

Massive public awareness campaigns are needed to alert parents that services are available and that children will benefit by participating in a program.

When P.L. 94-142 was passed, there were children with disabilities who were not enrolled in school. Some children and parents had been informed that schools did not serve children with particular disabilities, or that their situation was not covered. These "out of school children" were located through a massive "child-find" effort at both state and federal levels. The large-scale provision of services to preschool children with disabilities calls for a similar child-find effort. Not only do parents need to be informed about ECH programs, but they need to be convinced that such programs are valuable and useful for their children. In most states,

children under the age of 5 are not routinely served in the public schools. Parents—including those of children with disabilities—do not automatically see ECH as an option for their children, and they need to be informed about the advantages of early intervention, the types of services provided, and the wisdom of participating in such services.

When considering young children with behavioral disorders, the problem of public awareness is compounded. There is considerable reluctance to label young children as BD, and such reluctance is justified. Many states use categorical labels for older children, but rely on generic or cross-categorical labels for children under age 5. The terms "early childhood handicapped" and "developmentally delayed" often are applied to this group. This is not to say that BD and SED do not occur in this group. In fact, numbers are hard to come by because of these definitional decisions, but the numbers of young children with behavioral disorders seem to be rising dramatically. The numbers of infants born addicted to crack, cocaine, and other drugs have become a national nightmare, with estimates ranging as high as 376,000 per year (Gordon, 1989). These children seem to be exhibiting a constellation of symptoms that includes some serious behavioral problems. Children diagnosed with pervasive developmental disorder (PDD)—a disorder that involves distortions in the whole range of psychological functions during development, including attention, perception, language, social skills and motor skills—seem to be showing up in greater numbers in ECH classes. Yet awareness of these increases, even within the field of special education, is not high.

4. Developmental Therapy

This program model bases its curriculum on a child's current level of performance and behavior rather than chronological age.

Many ECH teachers consider the development and dissemination of intervention strategies for young children with behavior disorders the most pressing need in this area of collaboration. Whereas many textbooks discuss developmental sequence and the influence of temperament—certainly important issues—the actual "methods" sections involving behavior are often slim. Even so, many strategies, intervention models, and theoretical perspectives are already well delineated and may assist teachers working with young children.

One program that clearly crosses the boundary between ECH and BD is Developmental Therapy. This is a comprehensive program for children with emotional disturbance, behavioral disorders, and autism.

The program was created under the supervision of Mary M. Wood at the Rutland Center, University of Georgia. The philosophical assumptions underlying this program (Wood, 1986) mirror the concerns of many ECH educators.

Assumption One: Emotional and behavioral disturbances in a young child are interwoven with normal functioning and often are difficult to differentiate. Most professionals in special education place heavy emphasis on the "more like than unlike" aspects of the children they serve. This is particularly true in dealing with behavior disorders in young children, and leads to the often appropriate reluctance to label youngsters.

Assumption Two: Normal processes of physical and psychological development follow in a hierarchy of stages and sequences well documented in the literature. The developmental model continues to be the most widely accepted theoretical perspective in working with young children with disabilities (Berkeley & Ludlow, 1989). Although there is criticism concerning the use of this model to design curriculum for all children (particularly those with disabilities) (Bailey & Wolery, 1984; Garwood, 1982), its use as a guide for overall program direction is widespread.

Assumption Three: The normal process of change is uniquely individual, yet predictable, and occurs in relation to environmental conditions, experiences, and biological constituents and to the foundation laid in prior experience. Sensible use of a developmental framework requires constant modification based on the individual needs, strengths, and behaviors of the child. Using an ecological approach that considers ethnocultural aspects of the child's prior and current experiences will produce an individualized program that is well matched to the child's present and changing needs.

Assumption Four: The young child's self-knowledge, self-confidence, and willingness to take risks in new situations grows out of significant, pleasurable experiences. There is much appropriate concern at all age levels of student intervention with the topic of self-esteem. The term appears on most lists of educator's objectives, parents' concerns, drug prevention programs, and school board goals. Professionals connected with the education and treatment of students with behavioral disorders have long recognized the importance of self-esteem if the student is to learn successful social skills and methods of interacting with others.

Assumption Five: The young child learns and grows by experiences. Experiential education is clearly a basic tenet of early childhood

education, from early child development workers such as Froebel to current writers (Peterson, 1987).

The development and exploration of these basic philosophical statements has led to the construction of an intervention program based on five stages of development across four areas: behavior, communication, socialization, and (pre)academic skills. Each of the five stages has a unifying theme and specific curriculum goals for each area. Drawing from the work of Wood (1986), the five stages are as follows:

1. Responding to the environment with pleasure.
2. Responding to the environment with success.
3. Learning skills for successful group participation.
4. Investing in group processes.
5. Applying individual and group skills to new situations.

The developmental therapy program has been successfully used with children from 3 to 14 years of age, with most preschool focus being on the first two levels (Wood & Swan, 1978). Children entering the program are assessed with The Developmental Therapy Objectives Rating Form (DTORF), both for initial assessment and to document possible changes in performance over time. A total of 62 specific competencies or objectives in the four areas of behavior, communication, socialization, and preacademic skills are covered. The assessment determines which of these objectives the child is currently ready to work on. It is not unusual for a child to be at Stage 1 in one area and at Stage 2 in another. Use of the DTORF in a center-based ECH class can provide useful information on grouping for specific types of instruction, because it is not tied to chronological age, but to current performance and behavior.

The developmental therapy classroom is a carefully organized program, with attention given to staffing, physical arrangement of space, materials, parent involvement/home visits, and schedule. In addition to the texts previously cited (Wood, 1975, 1986), there are *Developmental Therapy Sourcebooks* that contain discussions of and suggested activities in the areas of fantasy, storytelling, the arts, recreation, music, sociodrama, adaptive physical education, and play (Wood, 1981).

Of particular interest to those working with young children with behavior disorders is a guide sheet, written by developmental therapy staff members, for regular education teachers which helps them identify children who may be having emotional difficulties (Wood, 1972). Such checklists are susceptible to numerous technical shortcomings (validity, reliability) and therefore do not begin to answer all the questions we

need to pose about the student, but they can assist teachers in focusing their thoughts about troubled children. Behaviors cited on the form include the following: short attention span, restless or hyperactive, does not complete tasks, listening difficulties, avoids participation with children or adults, repetitive behavior, ritualistic or unusual behavior, resistant to direction, unusual language content, speech problems, physical complaints, echoes others' speech, lack of self-help skills, self-aggressive or self-derogatory, temperamental, overly sensitive, sad, and irritable. Of course there are many reasons why any of these behaviors could be occurring, but the list provides a place to start in discussions with regular preschool or elementary teachers who have noticed "something wrong." A complete list of behaviors and definitions is provided by Wood (1972).

5. Engineered or Orchestrated Classroom

This model focuses on creating a "harmonious learning climate," where every child is seen as a learner.

While developmental therapy seems an obvious tool for teachers of young children with behavior disorders, there are other "BD standards" that may also be of use to ECH teachers. Many of the methods that are part of a school-age BD teacher's handbook may be equally applicable, or in need of only minor modification, to be of use to the ECH teacher. An example is Frank Hewett's engineered/orchestrated classroom.

This is a theory and intervention model first developed in the 1960s by Frank Hewett, Frank Taylor, and their colleagues at UCLA and in the Santa Monica, California, school system, and it is probably one of the most copied educational programs for children with serious emotional disturbance and behavior disorders (Rizzo & Zabel, 1988). For a full description of this program, the reader is referred to *The Emotionally Disturbed Child in the Classroom: The Orchestration of Success* (Hewett, 1968; Hewett & Taylor, 1980). An element of the model that may be of particular significance for ECH teachers is the discussion of a "harmonious learning climate." Establishment of such a climate is based on adherence to several tenets that define good teaching, particularly with children with behavior disorders. The tenets include such concepts as "Every child is a learner" and "Give the child the dignity of being expected to learn." These guidelines, along with a third, "Don't ask if the child is ready to learn, ask if the classroom is ready to teach," give clear direction to the appropriate design of an ECH class, as well as one for older children.

Other concepts, such as "Recognize that time is often our enemy," seem especially applicable to the ECH classroom, where the swift approach of general education and the larger and more complex school environment is a constant source of concern. Hewett also reminds us to "Think thimblefuls." He suggests that if we think about teaching and learning in "bucketfuls," we may defeat ourselves and our children. The notion of appropriate expectations of learning rate is important to pass on to parents, as well. Several other aspects of a harmonious learning climate, such as "Think sequentially," "Consider conditions," and "Consider consequences," are also valuable to the ECH teacher seeking to assist young children with behavior disorders. Finally, the work of Hewett, along with that of Wood, reflects significant attention to physical arrangement of the classroom, developmental learning goals, and the use of various learning centers strategically located around the classroom.

6. Psychoeducational Model

This program provides a classroom where the security and comfort of a predictable structure and schedule is a central factor.

Another strategy helpful to teachers of children with behavior disorders is found in the work of Fritz Redl and David Wineman (1951, 1952). Although these authors primarily describe their work with predelinquent boys at Pioneer House, a residential treatment center in Detroit, Michigan, their philosophy and techniques are used with children of all ages who are experiencing behavior problems. According to Rizzo and Zabel (1988), Redl and Wineman, along with other psychoeducators, developed four major interventions:

1. Design of a therapeutic milieu.
2. Programming for ego support.
3. Antiseptic manipulation of surface behavior.
4. Clinical exploitation of life events.

The first three of these interventions are especially useful for educators of young children. The fourth intervention approach, clinical exploitation of life events, refers primarily to the strategy of "life space interviewing." This intervention is definitely geared to older, verbal groups of students; but its focus on understanding the facts surrounding

an event, understanding feelings, and developing solutions may be helpful to ECH teachers in their own interpretations of classroom disturbances.

The construction of a therapeutic milieu, a physical and psychological environment of caring and support, is a crucial step in intervening with children with emotional disturbance or behavior disorders. As previously mentioned, Wood and Hewett both attended to the setting in which education or therapy is to take place, and Redl and Wineman also found this an important consideration. Two significant aspects of creating a therapeutic milieu are structure and environmental stimulation. When rules and structure are thoughtfully applied, they can become freeing rather than confining. Young children with behavior disorders, while still needing freedom and encouragement to explore and discover, also need the security and comfort of predictable structure and schedule to provide a secure base from which to operate. As Carl Fenichel, founder of the League School in New York, stated, "disorganized children need someone to organize their world for them" (1971, p. 339). The situations in which many children and families find themselves, with uncertain mealtimes, fluctuating daily schedules, and little structure in the home, increase the need for teachers to define and ease children toward a sense of order and structure in the school day. This simple intervention strategy can do a great deal toward easing the anxiety and fear many children seem to experience when they enter a school program.

The second aspect of a therapeutic milieu, environmental stimulation, refers to the need for a colorful, engaging, and appealing environment. Although some early researchers questioned the use of color and stimulation with some children with disabilities (Cruikshank, Bentzen, Ratzeburg, & Tannhauser, 1961), current research indicates that an engaging physical environment is not only desirable from an esthetic point of view, but is actually an aid to attention and learning (Zentall, 1983).

Programming for what Redl and Wineman have called "ego support," the second major intervention, involves building self-esteem by programming for success. As discussed previously, the strong need for self-esteem by many children with behavioral disorders dictates the use of this technique by those who work with them. Careful assessment and planning are necessary to reduce the instances of failure and increase the success experiences in the classroom and play area. As the teacher designs learning experiences and activities, he or she should carefully plan instructional steps so that children perceive themselves as competent and able. Such program design requires thoughtful sequencing, grouping and cultural sensitivity—respecting the child's language, ability, and perception of appropriate group behavior (independent or interdependent).

A particularly unusual feature of Redl and Wineman's work is their list of "Techniques for the antiseptic manipulation of surface behavior." This creative list of interventions presents relatively simple, straightforward strategies for stopping disruptive or potentially disruptive behavior. Although their techniques are primarily geared for the elementary or secondary classroom, many are applicable to preschool students. Some examples include the following:

- *Planned Ignoral.* The teacher uses prior experience to decide that a particular behavior is primarily attention seeking and can be ignored. This approach works with behaviors that do not harm the child or others and that are designed primarily to annoy or draw attention. Behaviors such as noisemaking, crying for an object or for attention, and pouting are particularly responsive to this technique. One caution with this approach—the behavior almost *always* gets worse before it gets better, and although this suggests that the teacher is not dealing with the behavior appropriately, patience will be rewarded.
- *Proximity and Touch Control.* The teacher moves close to the child who is being disruptive. Sometimes the mere physical presence of an attentive adult will halt the disruptions; and sometimes a touch on the shoulder or a pat on the back is useful. This approach does not call attention to the behavior, but the message is communicated that the teacher is aware of what is going on.
- *Hypodermic Infusion of Affection.* This technique involves pouring on an extra large dose of caring, hugs (if appropriate), and positive statements, such as "What a great storyteller you are!" or "You really made Evan feel good when you did that!" This simple intervention can often deflect a child on a downhill slide toward a bad day, often surprising a child out of a negative mood.
- *Tension Decontamination Through Humor.* This approach uses humor (not directed toward the child) to defuse a potentially negative situation.
- *Antiseptic Bouncing.* This strategy suggests removing a child from a potentially negative or tense situation by inventing a task or errand and asking the child to do it. This has the advantage of making the child feel important, while removing him or her from the impending altercation.

These are just examples of the many simple techniques provided by Redl and Wineman. Their discussion of children's lives and early development experiences make fascinating reading for anyone working with children with behavior disorders. Inasmuch as the bulk of the

support for these techniques is clinical lore, practitioners are urged to thoroughly document the impact of the strategy and be prepared to make any necessary adjustments.

7. Behavior Modification

This approach uses interventions based on positive reinforcement, time out, and natural consequences to shape appropriate behavior.

In contrast to psychoeducational approaches, behavior modification strategies have been more completely defined in ECH texts and training programs. Behavior modification strategies, of course, are of prime importance to anyone working with children with behavior disorders. Teachers of young children routinely use interventions based on principles of positive reinforcement, time out, and natural consequences, although it would be inappropriate to assume that these are used in the same way as with older children. Attention must always be given to developmental appropriateness when using any of these strategies. ECH textbooks often provide good background in this area, and other sources (e.g., Allen, 1982) provide excellent discussions of issues of special concern to this group, such as generalization of behavior. Some topics may need more attention in ECH classrooms, such as the use of group reinforcement strategies to encourage cooperation (e.g., rewarding children for a particular behavior by allowing them to color in a square on a design—any time the behavior is exhibited by anyone, they may color in a square; when all squares are colored, a group event such as a special story, a walk to the park, or a special snack takes place). Discussions of other behavior modification techniques are readily available (e.g., Allen, 1982; Gallagher, 1988; Rizzo & Zabel, 1989; Zabel, 1986).

8. Social Skills Development

Social skills are central to the development of young children and generally need to be directly taught to the young child with a behavior disorder.

The topic of social skills training is one that has had much prominence in the area of BD. The idea that social and interaction skills need to be directly taught, rather than just encouraged, has found great acceptance among teachers and other professionals. Commercially available

programs have been developed for students of different ages (Camp & Bash, 1981; Hazel, Schumaker, Sherman, & Sheldon-Wildgen, 1982; McGinnis & Goldstein, 1984; Vernon, 1989; Walker et al., 1982), and university training programs routinely include courses or coursework designed to aid teachers in using these materials. Not all programs, however, have been equally well validated, and many lack documentation of effectiveness.

The social skills movement with preschool children has taken a slightly different direction. Research in this area seems to be focusing on identification of appropriate assessment instruments—asking the right questions and carefully defining the sorts of skills and interventions that are of use to the children and the field. As Strain and Kohler (1989) have pointed out, at least nine different questions are crucial to the development and evaluation of the social skills teaching program:

1. Who needs social skills training?
2. What skills should be taught?
3. At what rates and contextual conditions should these skills be used?
4. Who should act as the teaching agent?
5. How and where should the skills be taught?
6. How long should teaching efforts persist?
7. Do the teaching efforts produce a behavior change?
8. Are these changes generalizable across settings, forms, and over time?
9. Are the new behaviors important for their users? (p. 133)

As we attempt to answer these questions concerning young children whose social development and interaction style is somehow "deviant" or "disordered," the magnitude of the task becomes clear. Odom and McEvoy (1989a) have noted that even when social skills intervention is carefully planned and monitored, physically aggressive children tend to "turn off" other children, and their behavior remains socially inappropriate. While failure is clearly an important issue for children of all ages, young children rely extensively on play and peer social interaction for learning. Available evidence suggests that play behavior of young children with disabilities relates highly to each child's cognitive, language, and *social* skills (Fewell & Kaminski, 1989); a deficit in play skills is likely to negatively influence the acquisition of other skills crucial to continued learning and growth. Understandably, issues surrounding social skill acquisition and teaching appropriate play skills to young children will continue to be the focus of major research efforts.

As Odom and McEvoy (1989a) noted, 75% of the teachers contacted in a survey said they needed to teach social interaction skills. Strain and Kohler's (1989) nine questions need to be placed in the context of the large numbers of culturally and linguistically diverse exceptional children (CLDE) who are and will be entering ECH programs. Teaching social interaction strategies that are culturally sensitive, as well as promoting positive interactions, is clearly a challenge for the 1990s.

A second issue related to the development of social skills is that of integrating young children with behavior problems with same-age peers without disabilities. This topic is one of major interest to educators as states begin their implementation of P.L. 99-457. The "mainstreaming" or "least restrictive environment" questions as they apply to children under age 5 must be addressed. As with all children experiencing behavioral difficulties, young children must learn to get along with peers: "The ability to get along with one's peers, to make friends, to learn from others, and to cooperate are hallmarks of socially skillful children" (Strain & Kohler, 1989, p. 129). Many ECH programs, however, though located in public schools, do not include same-age peers. Integrated programs, or integration opportunities with same-age peers, are a critical part of programs designed to remediate behavioral problems.

Along with the provision of same-age peers, however, comes the need to systematically design the physical environment and to define the interventions and expected outcomes with the peer models and children with disabilities (Odom & McEvoy, 1989b; Odom et al., 1988). Much is as yet unknown about ways to promote generalization and maintenance of skills over time. Though the use of peers seems an obvious and promising method for learning and maintaining skills, actual methodology is in the formative stage.

9. Focus on Family

Focus on family strengths and needs rather than on child deficits provides a constructive basis for working together.

The area of parental and family involvement is at the core of most ECH programs. As P.L. 99-457 takes effect and programs become more school based, it will be a challenge to maintain this close and crucial family connection. Professionals serving students with behavior disorders have long wrestled with the need for effective parent communication and involvement, and it seems that the work being done in this area through ECH programs will benefit the entire field of special education. As was mentioned in the discussion of Part H legislation and its attention to prevention (Figure 2), many of the concerns identified in this area are

also relevant to the field of behavior disorders. The individual family service plan (IFSP), with its focus on family strengths and needs rather than on child deficits, is a tool primarily associated with infant intervention programs, but it could be extended to families with children with disabilities, particularly behavior disorders. New strategies for enabling (Dunst, Trivette, & Deal, 1988), for assessing (Bailey & Simeonsson, 1989; Dunst et al., 1988), and for implementing plans (Johnson, McGonigel, & Kaufman, 1989) are being tried, tested, evaluated, and publicized).

10. Teacher Training and Professional Resources

Teacher training programs and textbook developers need to provide both general and special education with more information about behavioral disabilities, strategies that work, and ways of collaborating within schools and with outside agencies.

As states move toward instituting programs for 3- to 5-year-olds with disabilities, alternative certification methods are being considered. State certification of some teachers is accomplished by having a separate ECH certificate, one that is cross-categorical and covers all disabilities. Other states have tied work with young children to categorical areas, such as certification in mental retardation, behavioral disorder, and visually and/or hearing impaired, as the base and lowering the age levels served by these professionals. Both approaches to certification have strong and weak points, and the issues concerning textbooks that represent disciplines highlight the difficulties in obtaining appropriate and accurate training information. It will only be through sound collaborative efforts between ECH and the various divisions and categories of special education that appropriate training and resource materials will be developed. There are certainly many similarities in teaching preschool and elementary students, such as student-centered decision making, curriculum designed to promote appropriate development, and social skills training for appropriate interaction. All are important to education at any age. It is also necessary, however, to determine what differences exist and examine training programs and strategies to ensure quality teachers for all children with disabilities.

Another issue facing both special and general education that has particular relevance for ECH is that of training teachers and other professionals in the areas of consultation (providing advice and professional expertise on a particular subject) and collaboration (working

cooperatively on a project). ECH has historically been a multidisciplinary enterprise, and that broad focus must be maintained. In addition, as more young children with disabilities are placed in regular day care and preschool facilities, as children move from ECH classes to regular kindergartens, and as more and more diverse types of children begin to enter the mainstream school system from specialized environments (such as programs for infants born addicted to crack and cocaine), it becomes essential that ECH teachers be well prepared in the collaboration process. Combining the specialized knowledge of the ECH educator with the process techniques of the appropriately trained educational consultant (Heron & Harris, 1987) will be of major importance.

In an attempt to discern how we are communicating with each other across the BD and ECH boundaries in special education, an informal textbook survey was conducted. Eight textbooks on behavior disorders were examined and their indexes searched for references to infants, young children, early childhood, or other such terms. The only related topics discovered in these texts were infantile autism (which usually did not discuss the manifestations in young children), temperament, and normal social development. None of these textbooks specially addressed diagnosis, intervention, or programming for children under age 5. Next, to assess the knowledge base in early childhood education, 10 ECH texts were similarly surveyed for information dealing with behavioral disorders. Most texts included one chapter on behavior or social-emotional development, occasionally in combination with another area such as speech/language or cognitive development. Most texts discussed developmental characteristics, assessment information, and social skills development and provided brief overviews of behavioral intervention systems. This is a slightly better showing than the BD texts provided, but probably does not reflect sufficient content or treatment to acquaint ECH teachers with the range of behavioral problems they may encounter in their classes.

As we move into the 1990s and acknowledge the areas of professional concern that affect children with disabilities and their families, we would do well to reflect on our history. That is, difficulties surrounding the implementation of P.L. 94–142 have taught us many things about how to address issues in special education (Martin, 1989). A major lesson learned is that parents and families are not "peripheral" to the education of their children; rather they are at the heart of the process. Further, we have learned that engaging parents as true partners in their children's education provides benefits for everyone involved. And we have learned that no simple discipline or knowledge base holds all (or even most) of the answers for educating and empowering any group of children.

The public school population is changing, almost as we watch. New problems are arising that demand fresh solutions. More languages, more diverse cultures, less money, more enthusiasm, less enthusiasm, older

children, younger children—these are but a few of the constantly changing aspects of school. Our comfort level in this climate of rapid change may be directly related to our ability to find information and support among our colleagues. It is becoming clear to everyone that no one process, technique, model, or intervention can suffice. Frank Hewett (1990) stated that we have reached a point in special education when we can stop looking for the miracle answer and start relying on the collective wisdom that already exists.

It is only through shared resources and talents that a difference can be made. But we can take hope from the knowledge that there *are* resources, talents, interventions, and interveners—there are models that work and people eager to share ideas, results, and information to effect real change in the lives of children.

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